April 7, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0755-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 49-year-old woman who slipped on a wet floor on ___, causing her to almost fall, catching herself. This ultimately led to a lumbar laminectomy in 1998 and, because of persistent pain, also led to a 1999 repeat surgery with implantation of cages. She unfortunately did worse postoperatively with a right foot drop. She has pain in the mid to lower back with radiating pain across both sides and down the entire right leg to the bottom of her foot. She has associated paresthesias. She has also fallen again and since falling has pain down her right arm with associated sensory abnormalities.

Upon examination, she limps and has a right foot droop. There is limited range of motion of the lumbar-sacral spine with straight leg raising that is positive on the right at 45 degrees and positive on the left at 45 degrees for back pain only. There is sensory hypesthesia as well in the right leg. Deep tendon reflexes are absent in the ankles.

This patient had a failed spinal cord stimulator trial and as well failed a morphine pump trial, as she could not tolerate morphine. A lumbar myelogram did not show any significant compression, nor did nit show any aracnoiditis. She was recommended to have lumbar facet blocks, as she has had zero degrees of extension at the lumbosacral junction on examination. Her EMG was consistent with right L4/5 radicular dysfunction.

REQUESTED SERVICE

Bilateral facet injections (x1) at L2/3, L3/4 and L5/S1 are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The decision at the present time is that there is no indication for the medical necessity of proposed bilateral fact joint injections. Treatment guidelines and care standards indicate that there needs to be strongly positive neuroradiographic findings suggestive of facet mediatead painin conjunction with tenderness to facet palpation on examination, neither of which have been documented to an extent which would substantiate the need for the proposed bilateral lumbar facet blocks. Therefore, to reiterate, the proposed bilateral facet blocks at L2/3, L3/4 and L5/S1 are determined by the ___ reviewer to be not medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of April 2003.